SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Filing at a Glance

Company: Companion Life Insurance Company

Product Name: HOEM01GR10	SERFF Tr Num: CMLX-126613507	State: Arkansas
TOI: HOrg03 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 45580
Sub-TOI: HOrg03.000 Health - Other	Co Tr Num: HH AR0012201F01	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: SPI CompanionLife	Disposition Date: 05/12/2010
	Date Submitted: 05/04/2010	Disposition Status: Approved-Closed
Implementation Date Requested: 05/04/2010		Implementation Date:

State Filing Description:

General Information

Project Name: HOEM01GR10	Status of Filing in Domicile: Pending
Project Number: HH AR0012201F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 05/12/2010	Explanation for Other Group Market Type:
	State Status Changed: 05/12/2010
Deemer Date:	Created By: SPI CompanionLife
Submitted By: SPI CompanionLife	Corresponding Filing Tracking Number:

Filing Description:

Enclosed herewith for your consideration are Companion Life Insurance Company's Group Supplemental Medical Expense Insurance forms. The forms are new and will not replace any forms that have been previously approved in your state.

This is a limited benefit indemnity type product which provides supplemental benefits to existing employee Health Benefit Plans. It covers certain portions of the out-of-pocket expenses the employees and their families incur under their Health Benefit Plan. The coverage will be available to eligible employees and their families on a guaranteed issue basis (subject to enrollment, actively at work and participation requirements) with premiums being paid on either an employer-paid or employee-paid payroll deduction basis. The plan does not contain a pre-existing condition provision. In order for

this policy to be issued, a Health Benefit Plan is required.

This product is not intended to be a group health plan for purposes of renewability and portability under HIPAA.

The filing was submitted to our domiciliary state, South Carolina, on April 30, 2010.

Company and Contact

Filing Contact Information

Vivian Frederic, Contracts Compliance Specialist	vivian.frederic@companiongroup.com
7909 Parklane Rd	803-735-1251 [Phone] 46777 [Ext]
Columbia, SC 29223-5666	800-836-5433 [FAX]

Filing Company Information

Companion Life Insurance Company	CoCode: 77828	State of Domicile: South Carolina
7909 Parklane Rd, Suite 200	Group Code: 661	Company Type:
Columbia, SC 29223-5666	Group Name: Companion Life Insurance Company	State ID Number:
(803) 735-1251 ext. [Phone]	FEIN Number: 57-0523959	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Companion Life Insurance Company	$50.00	05/04/2010	36209850
Companion Life Insurance Company	$150.00	05/06/2010	36268649

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/12/2010	05/12/2010
Approved-Closed	Rosalind Minor	05/07/2010	05/07/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/05/2010	05/05/2010	SPI CompanionLife	05/06/2010	05/06/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group Supplemental Medical Expense Insurance Certificate	SPI CompanionLife	05/12/2010	05/12/2010

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Disposition

Disposition Date: 05/12/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Supplemental Medical Expense Insurance Policy	Approved-Closed	Yes
Form *(revised)*	Group Supplemental Medical Expense Insurance Certificate	Approved-Closed	Yes
Form	Group Supplemental Medical Expense Insurance Certificate	Replaced	Yes
Form	Group Supplemental Medical Expense Insurance Application	Approved-Closed	Yes
Form	Group Supplemental Medical Expense Insurance Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Disposition

Disposition Date: 05/07/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	Group Supplemental Medical Expense Insurance Policy	Approved-Closed	Yes
Form *(revised)*	Group Supplemental Medical Expense Insurance Certificate	Approved-Closed	Yes
Form	Group Supplemental Medical Expense Insurance Certificate	Replaced	Yes
Form	Group Supplemental Medical Expense Insurance Application	Approved-Closed	Yes
Form	Group Supplemental Medical Expense Insurance Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
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TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/05/2010
Submitted Date	05/05/2010
Respond By Date	06/04/2010

Dear Vivian Frederic,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Supplemental Medical Expense Insurance Policy, GAPP-4100 (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $200.00. Please submit an additional $150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/06/2010
Submitted Date	05/06/2010

Dear Rosalind Minor,

Comments:
Thank you for your message.

Response 1

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Comments: We are submitting the additional filing fees.

Related Objection 1

Applies To:

- Group Supplemental Medical Expense Insurance Policy, GAPP-4100 (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $200.00. Please submit an additional $150.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have any questions or need additional information, please let us know.

Sincerely,
SPI CompanionLife

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Amendment Letter

Submitted Date: 05/12/2010

Comments:

Attached is a revised certificate. The only change which has been made was the letters "AL" were changed to "AR" in the lower left-hand corner of page 6.

Thank you for agreeing to re-open this file in order that the typographical error could be corrected.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
GAPC-4100	Certificate	Group Supplemental Medical Expense Insurance Certificate	Initial				40.500	GAPC-4100.PDF

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Form Schedule

Lead Form Number: GAPP-4100

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/07/2010	GAPP-4100	Policy/Contract/Fraternal Certificate	Group Supplemental Medical Expense Insurance Policy	Initial		40.500	GAPP-4100.PDF
Approved-Closed 05/12/2010	GAPC-4100	Certificate	Group Supplemental Medical Expense Insurance Certificate	Initial		40.500	GAPC-4100.PDF
Approved-Closed 05/07/2010	GAPEMP-4100	Application/Enrollment Form	Group Supplemental Medical Expense Insurance Application	Initial		47.700	GAPEMP-4100.PDF
Approved-Closed 05/07/2010	GAPENR-4100	Application/Enrollment Form	Group Supplemental Medical Expense Insurance Enrollment Form	Initial		45.600	GAPENR-4100.PDF

COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200
Columbia, SC 29223

POLICY NUMBER: [MG-101]

POLICYHOLDER: [ABC Employer]

STATE OF ISSUE: [South Carolina]

POLICY EFFECTIVE DATE: [Month, Day, Year]

POLICY ANNIVERSARY DATE: [Month Day, Year and each Month Day thereafter]

Companion Life Insurance Company ("the Company") agrees to pay benefits provided by the Policy in accordance with its terms and conditions.

The Policy is issued by acceptance of the application of the Policyholder (a copy of which is attached) and receipt by the Company of the premiums.

All periods of time under the Policy begin and end at 12:01 a.m. Local Time at the Policyholder's business address.

The Policyholder or the Company may terminate the Policy on any premium due date on or after the first Policy Anniversary Date. Written notice must be provided to the other party at least 31 days prior to termination.

The Policy is issued by Companion Life Insurance Company at Columbia, South Carolina on the Policy Effective Date.

COMPANION LIFE INSURANCE COMPANY

President

GROUP SUPPLEMENTAL MEDICAL EXPENSE INSURANCE POLICY
THIS IS A LIMITED BENEFIT POLICY
Please read the Policy carefully.

TABLE OF CONTENTS

PART I - SCHEDULE OF BENEFITS

Insurance benefits are determined by this Schedule of Benefits and the terms of the Policy.

[Benefit	Benefit Amount
Inpatient Hospital Benefit	
Inpatient Hospital Benefit Year Maximum	
per Insured Person	[$500 – $10,000]
per family	3 times the Inpatient Hospital Benefit Year Maximum per Insured Person
Outpatient Hospital Benefit	
Outpatient Hospital Benefit Year Maximum	
per Insured Person	[40-70%] of the Inpatient Hospital Benefit Year Maximum
per family	3 times the Outpatient Hospital Benefit Year Maximum per Insured Person
Ambulance Benefit	
(Accident Only)	
Ambulance Benefit Year Maximum	
per Insured Person	[$0-$350]
per family	3 times the Ambulance Benefit Year Maximum per Insured Person
[Physician Office Visit Benefit	
per visit per Insured Person	[$5 - $50] per visit]]

PART II - DEFINITIONS

When used in the Policy the following words and phrases have the meaning given.

Accident means an external event occurring by chance or unintentionally after the Insured Person's Effective Date of coverage. An Accident must be independent of any Sickness.

Actively at Work/Active Employment means the Insured Person is performing the material and substantial duties of the Insured Person's regular occupation on a full-time basis at the Insured Person's regular place of employment or at any business location to which the Insured Person is required to travel.

For the purposes of this definition, a vacation day, holiday or an authorized leave of absence not due to an Injury or Sickness is considered a regular work day.

Benefit Year means a period of one year which starts and ends at midnight on the dates shown in the employer's application.

Benefit Year Maximum means the amounts shown in the Schedule of Benefits.

Coinsurance/Copayment means the expenses covered and specified by the Insured Person's Health Benefit Plan as being the amount, other than deductibles, to be paid by the Insured Person.

Company means Companion Life Insurance Company, Columbia, South Carolina.

Complications of Pregnancy means any of the following: 1) a condition that, while affected by pregnancy, is still classified by accepted medical standards as a Sickness apart from the normal bodily changes that accompany pregnancy; 2) a non-elective cesarean section; 3) an extrauterine or ectopic pregnancy; or 4) a spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include: false labor, premature labor, high risk pregnancy or delivery, occasional spotting, Physician-prescribed rest, morning sickness, pre-eclampsia or placenta previa or similar conditions that occur in a difficult pregnancy.

Covered Charge means those expenses described in the Policy that are payable under both the Policy and the Insured Person's Health Benefit Plan. Expenses that are excluded under either the Policy or the Insured Person's Health Benefit Plan are not Covered Charges.

Dependent means any of the following whose coverage under the Policy has become effective and has not ended:

1. the Insured's lawful spouse;
2. the unmarried Dependent child or children of the Insured or of the Insured's spouse who are under 19 years of age (23 years of age if a full-time student); and
3. the unmarried handicapped Dependent child of the Insured or of the Insured's spouse who has attained age 19, provided such child was an Insured Person on the day immediately prior to attaining age 19, is mentally handicapped or physically incapable of earning his or her own living. Proof of incapacity must be furnished to the Company, but not more than once in any 12-month period.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree. Full-time, as used in this definition, means actively attending at least the minimum number of hours of class a week the school considers as full-time status.

A spouse or child covered under the Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both covered as Insureds, a child will be the Dependent of only one parent.

Effective Date means, for the Policy, the date shown in the Policy face page. Effective Date means, for an Insured Person, the date the Insured Person becomes covered under the Policy as shown in the Insured's Certificate. The Effective Date will begin at 12:01 a.m. Local Time at the Policyholder's business address.

Health Benefit Plan means any major medical or comprehensive medical plan through which an Insured Person has coverage. It may be a self-funded plan or provided through insurance. Health Benefit Plan does not include any limited medical program, Medicare, Medicaid, CHAMPUS, or TRICARE.

Hospital means an institution that meets all the following requirements:

1. it must be operated according to law;
2. it must give 24-hour medical care, diagnosis and treatment to the sick or injured on an inpatient basis;
3. it must provide diagnostic and surgical facilities supervised by Physicians;
4. Registered Nurses must be on 24-hour call or duty; and
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Hospital does not mean a convalescent, nursing, rest or extended care facility or a facility operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facility is operated as a separate institution by a Hospital.

Immediate Family means the Insured or the Insured Person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing with that Insured Person.

Injury means bodily injury sustained directly and independently of all other causes, which results in loss covered by the Policy. The Injury must occur and the loss must begin while the coverage for the Insured Person is in force under the Policy.

Inpatient means that the Insured Person is a registered bed patient in a Hospital for more than 23 continuous hours and is charged room and board by the facility. The Insured Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician.

Insured means an employee of the Policyholder whose coverage under the Policy has become effective and has not ended. The Insured must be Actively at Work with the Policyholder.

Insured Person means either an Insured or Dependent.

Late Entrant means a person who applies for coverage under the Policy more than 31 days after he or she initially becomes eligible.

Outpatient means the Insured Person is not an Inpatient when covered services are received.

Physician means a person licensed by the state in which he or she is a resident to practice the healing arts. He or she must be practicing within the scope of his or her license for the service or treatment given. He or she may not be the Insured Person or a member of the Insured Person's Immediate Family.

Policy means the contract issued to the Policyholder providing the benefits described.

Policyholder means the employer to whom the Policy is issued as shown in the Policy.

Regular and Customary Activities means: 1) for the Insured or a working Dependent, he or she is actively performing all the duties of his or her regular occupation; and 2) for a non-working Dependent, he or she is regularly performing the normal activities of a person of like age and good health.

Schedule of Benefits means the schedule in the Policy or Certificate which contains the benefits provided by the Policy.

Sickness means a bodily disorder, disease or illness that begins while the Insured Person's coverage is in force, including Complications of Pregnancy.

Total Disability/Totally Disabled means that because of Injury or Sickness, the Insured Person cannot perform the Insured Person's Regular and Customary Activities. The loss of a professional or occupational license for any reason does not, in itself, constitute Total Disability.

PART III - ELIGIBILITY AND EFFECTIVE DATE

New eligible persons will be added from time to time. In no event will coverage for any person become effective before the Policy Effective Date.

Insured Eligibility and Effective Date. Eligibility requirements are defined in the Policyholder's application. To be eligible, the Insured must be covered under a Health Benefit Plan. Coverage will be effective on the first day of the month, subject to approval of the Insured's individual enrollment form and payment of the first premium, provided the Insured is Actively at Work.

If the Insured is not engaged in the Insured's Regular and Customary Activities on the day coverage would otherwise begin, coverage will begin on the first day of the month following the day the Insured returns to Active Employment.

Dependent Eligibility and Effective Date. Insurance may be available to Dependents only if the Insured is eligible for such insurance under the Policy. An Insured's Dependents will be eligible for insurance under the Policy if the Dependent meets the eligibility requirements in the Policyholder's application and is covered under a Health Benefit Plan. Coverage will be effective on the first day of the month, subject to approval of the Dependent's individual enrollment form and payment of the first premium, provided the Dependent is engaging in the Dependent's Regular and Customary Activities.

If the Dependent is not engaged in the Dependent's Regular and Customary Activities on the day coverage would otherwise begin, coverage will begin on the first day of the month following the day the Dependent engages in the Dependent's Regular and Customary Activities. In no event will coverage for any Dependent become effective before the Insured's Effective Date.

Newborn and Adopted Children Eligibility and Effective Date. Coverage under the Policy for a newborn child, adopted child, child placed with the Insured for adoption, or child for whom the Insured is a party in a suit to adopt will be effective from the moment of birth, adoption, placement, or filing of such suit. Coverage for a newly born child will include coverage for Injury, Sickness, congenital defects, birth abnormalities and premature birth. In no event will coverage for such child become effective before the Insured's Effective Date.

We will pay benefits for a newborn child of the Insured until that child is 90 days old. Coverage may be continued beyond 90 days if the Insured notifies Us of the child's birth and pays the required premium, if any.

Adopted children will be covered on the same basis as a newborn child from the date of the filing of a petition for adoption if the Insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the date of birth. Coverage will cease on the date the child is removed from placement and the Insured's legal obligation terminates.

In no event will coverage for such child become effective before the Insured's Effective Date.

PART IV - BENEFITS

The following benefits are payable if the Insured Person is covered by a Health Benefit Plan when the Covered Charges are incurred. Each benefit is subject to the terms, conditions, limitations, exclusions and Benefit Year Maximums as described herein.

Inpatient Hospital Benefit. The Company will pay the benefit shown in the Schedule of Benefits for Covered Charges incurred by an Insured Person if:

1. the Covered Charges are incurred while the Insured Person is an Inpatient; and
2. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Inpatient Hospital Benefit shown in the Schedule of Benefits.

Outpatient Hospital Benefit. The Company will pay the benefit shown in the Schedule of Benefits for Covered Charges incurred by an Insured Person if:

1. the Covered Charges are for:
   a. treatment in a Hospital emergency room for Injury due to an Accident when the Insured Person is not subsequently considered an Inpatient;
   b. surgery performed in a Hospital Outpatient facility or a free-standing Outpatient surgery center; or
   c. radiological diagnostic testing performed in a Hospital Outpatient facility or a Magnetic Resonance Imaging (MRI) facility; and
2. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Outpatient Hospital Benefit shown in the Schedule of Benefits.

Ambulance Benefit. The Company will pay the benefit shown in the Schedule of Benefits if an Insured Person requires ambulance transportation to a Hospital or emergency center for Injuries sustained in an Accident. Ambulance transportation must be within 72 hours of the Accident, and be provided by a licensed professional ambulance company.

Benefits are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Ambulance Benefit shown in the Schedule of Benefits.

[Physician Office Visit Benefit. The Company will pay the benefit shown in the Schedule of Benefits if the Insured Person incurs a Covered Charge as the result of:

1. treatment by a Physician due to Sickness;
2. treatment by a Physician for an Injury due to an Accident; or
3. routine well child examinations and immunizations for Dependent children.

Benefits are only payable if the Covered Charges are incurred while the Insured Person is not an Inpatient.]

PART V - LIMITATIONS AND EXCLUSIONS

Limitations

Waiting Period for Late Entrants. [Benefits for Late Entrants will be limited to the Physician Office Visit Benefit during the Waiting Period.] After the expiration of the Waiting Period, Late Entrants will be eligible for all benefits listed in the Schedule of Benefits for any Covered Charge that is incurred after such Waiting Period. For this provision, "Waiting Period" means the first 30 days following the Late Entrant's Effective Date.

Exclusions

The Policy does not provide any benefits for the following:

1. any expenses incurred during any period the Insured Person does not have coverage under a Health Benefit Plan;
2. suicide or any attempt thereat, while sane or insane (in Colorado or Missouri, while sane);
3. any intentionally self-inflicted Injury or Sickness, while sane or insane (in Colorado or Missouri, while sane);
4. rest care or rehabilitative care and treatment;
5. voluntary abortion except, with respect to the Insured or the Insured's Dependent spouse:
   a. where the Insured's or the Insured's Dependent spouse's life would be endangered if the fetus were carried to term; or
   b. where medical complications have arisen from abortion;
6. Pregnancy of a Dependent child, except Complications of Pregnancy;
7. any Injury or Sickness as a result of Participation in a Riot, civil commotion, civil disobedience or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law;
8. an Insured Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause of loss occurred. A violation of law includes both misdemeanor and felony violations;
9. participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, scuba diving, stunt driving, rock climbing, flying ultra-light aircraft, skydiving, hang gliding or any hazardous sports activity for exhibition purposes;
10. Injury or Sickness as a result of air travel, except;
    a. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
    b. as a passenger for transportation only and not as a pilot or crew member;
11. any Injury that occurs while an Insured Person has been determined to be intoxicated:
    a. by judicial or administrative judgment or order;
    b. by evidence of an alcohol concentration in the Insured Person's blood, breath or urine which equals or exceeds the limits set by applicable motor vehicle laws; or
    c. by other evidence demonstrating the Insured Person was under the influence of any alcohol, narcotic, barbiturate or hallucinatory drug, unless the same was administered on the advice of a Physician and was taken according to the prescribed dosage;

    and the use of such substance was a proximate cause of the Injury;
12. alcoholism or drug use, unless administered on the advice of a Physician and was taken according to the prescribed dosage;
13. procedures associated with sex changes;
14. any treatment, drugs or surgery considered experimental by the American Medical Association, the Health Care Finance Administration or the Federal Drug Administration;
15. any loss while the Insured Person is in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. Upon notice to the Company of entering the Armed Forces, the Company will return to the Insured Person pro rata any premium paid, less any benefits paid, for any period during which the Insured Person is in such service;
16. Injury or Sickness for which compensation is payable under any Workers' Compensation Law, any Occupational Disease Law or similar legislation;
17. mental illness or functional or organic nervous disorders, regardless of the cause;

18. dental or vision services, including, but not limited to, treatment, surgery, extractions or x-rays, unless:
    a. resulting from an Injury occurring while the Insured Person's coverage under the Policy is in force and if performed within 12 months of the date of such Accident; or
    b. due to congenital disease or anomaly of a Dependent newborn child;
19. routine examinations, [other than well child examinations if the Physician Office Visit Benefit is listed in the Schedule of Benefits,] such as health exams, periodic check-ups or routine physicals; or
20. any expense for which benefits are excluded under the Insured Person's Major Medical Plan.

PART VI - TERMINATION OF INSURANCE

Termination of the Policy. The Policy may be terminated on the first of the following dates:

1. any premium due date on or after the first Policy Anniversary Date the Policyholder or the Company requests termination. Written notice must be provided to the other party at least 31 days prior to termination;
2. the next premium due date following the date the Policyholder's number of covered employees falls below the Company's guidelines; or
3. the date the Health Benefit Plan is modified, changed or terminated.

Termination of Insured's Coverage under the Policy. An Insured's coverage under the Policy automatically ends on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium has not been paid, except as provided in the Grace Period provision;
3. the date the Insured submits a fraudulent claim;
4. the date the Insured retires, is no longer an employee of the Policyholder, or is no longer Actively at Work; or
5. the date the Insured's Health Benefit Plan terminates.

Termination of Dependent's Coverage under the Policy. The insured Dependent's coverage under the Policy automatically ends on the first of the following dates:

1. the date the Insured's coverage terminates;
2. the date the required premium has not been paid, except as provided in the Grace Period provision;
3. the date the Dependent submits a fraudulent claim;
4. the date the Dependent ceases to be an eligible Dependent, as defined;
5. the date the Dependent's coverage under the Health Benefit Plan terminates; or
6. the date the Policy is modified to exclude Dependent coverage.

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination.

Continuation of Coverage. Coverage under the Policy will continue to the earlier of: 1) 31 days following termination of an Insured Person's coverage, or 2) the day the Insured Person otherwise becomes entitled to similar benefits under another policy.

This provision will not apply if coverage under the Insured Person's Health Benefit Plan terminates and the Health Benefit Plan does not have a similar continuation of coverage provision.

Extension of Benefits. This provision applies if an Insured Person is Hospital confined or Totally Disabled on the termination date of the Policy, unless termination is due to nonpayment of premiums. The Company will pay the same benefits for the duration of any Hospital confinement or Total Disability, or 90 days thereafter, whichever occurs first, if: 1) the Insured Person has incurred Covered Charges before the termination date; and 2) any Hospital confinement or Total Disability begins before the termination date. No further premium payment is required to qualify for this extension of benefits.

This provision will not apply if coverage under the Insured Person's Health Benefit Plan terminates and the Health Benefit Plan does not have a similar extension of benefits provision.

PART VII - PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date.

Premium Changes. The Company has the right to change the premium rates on any premium due date on or after the first Policy Anniversary Date. The Company will provide written notice at least 31 days before the date of change. The premium rates also may be changed at any time the terms of the Policy are changed. If a change in the Health Benefit Plan's deductible, Coinsurance or Copayment changes the Company's risk under the Policy, premium rates may be changed as of the date the Company's risk changed.

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums that are due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period.

Unpaid Premium. When a claim is paid for Covered Charges during the grace period, any premium due and unpaid for the Insured will be deducted from the claim payment.

PART VIII - CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's Home Office or to the Company's authorized administrator or agents with sufficient information to identify the Insured Person, will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not send the forms within that time, the Insured Person can send written proof of the occurrence, character and extent of loss for which the claim is made, within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's Home Office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required. Proof of loss includes a copy of the Health Benefit Plan's explanation of benefits.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All benefits will be payable to the Insured. Any benefits payable on or after the Insured's death will be paid to the Beneficiary.

Beneficiary means the person or entity named on the Company's records to receive the benefit after the Insured dies. The Insured may name any person as Beneficiary. If two or more Beneficiaries are named, each will receive an equal portion of the benefit, unless the Insured designates otherwise.

The Insured may change the Beneficiary at any time on forms the Company provides, unless an irrevocable Beneficiary is named or the insurance is assigned. The change date is the date the written request is signed by the Insured. If the Company pays the benefit before the Company receives a change request, the Company is released from further liability under the Policy to the extent of the Company's payment. If the Beneficiary dies at the same time as the Insured, or within 15 days after the Insured dies, the Company will pay the benefits as if the Insured survived the Beneficiary.

If there is no designated Beneficiary when the Insured dies, the Company will pay the benefits to the first of the following living persons:

1. the Insured's spouse;
2. the Insured's children, equally;
3. the Insured's parents, equally; or
4. the Insured's brothers and sisters, equally.

If none of the above persons is living on the date of the Insured's death, the Company will pay the benefits to the Insured's estate.

If any benefit is payable to an estate or to a minor or person not otherwise competent to give a valid release, the Company may pay such benefit, up to the amount allowed by the law of the state in which the minor or incompetent resides. Such payment will be made to the legal guardian of the minor or incompetent. Any payment made by the Company in good faith under this provision will fully discharge the Company to the extent of the payment.

Right of Recovery. If payment for claims exceeds the maximum amount payable under any benefit provisions or riders of the Policy, the Company has the right to recover the excess of such payments.

Physical Examination. At the Company's expense, the Company has the right to have the Insured Person examined as often as necessary while a claim is pending.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person lives, the limit is extended to meet the minimum time allowed by such law.

PART IX - GENERAL PROVISIONS

Certificates. Certificates will be provided to Insureds. The Certificate will describe the coverage provided, to whom benefits are paid and the provisions of the Policy that apply to Insured Persons. The Certificate is not a part of the Policy. Any conflict between the terms of the Certificate and the Policy will be decided in favor of the Policy. A copy of the Policy may be examined at the office of the Policyholder.

Choice of Physician. The Insured Person is free to be treated by any Physician the Insured Person chooses.

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Policyholder's application, which is attached to the Policy when issued, and the Insured's individual enrollment form, if any, are the entire contract between the parties. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured or the Insured's Beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured or the Insured's Beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying a premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not they become insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as they relate to this insurance. The Company can authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Misstatement of Age. If the age of an Insured Person has been misstated, the Company will make an equitable adjustment of premiums. The Company will refund to the Insured any excess premium paid over the amount due for the correct benefit amount. The Company will request payment for any overdue premium for the correct benefit amount. If the misstatement is discovered after a benefit is due and payable, the Company will reduce or increase the benefit amount payable by the amount of excess or overdue premium due to the misstatement. If an Insured Person is not eligible for coverage because of age, the Company will refund all premiums paid on and/or after the date the Insured Person was no longer eligible.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200
Columbia, SC 29223

POLICY NUMBER:	**[MG-101]**
POLICYHOLDER:	**[ABC Employer]**
STATE OF ISSUE:	**[South Carolina]**
CERTIFICATE EFFECTIVE DATE:	**[Month, Day, Year]**

The Certificate is issued to Insureds of the Policyholder whose coverage is in effect according to the Company's records.

The Certificate describes the principal provisions of the Policy. Benefits are provided only while coverage is in force for an Insured Person according to the terms of the Policy.

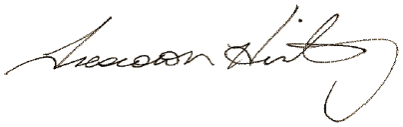
All periods of insurance begin and end at 12:01 a.m. Local Time at the Policyholder's business address.

This Certificate replaces all certificates that may have been previously issued to the Insured under the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Policy is issued by Companion Life Insurance Company at Columbia, South Carolina on the Policy Effective Date.

COMPANION LIFE INSURANCE COMPANY



President

GROUP SUPPLEMENTAL MEDICAL EXPENSE INSURANCE CERTIFICATE
THIS IS A LIMITED BENEFIT CERTIFICATE
Please read the Certificate carefully.

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NOTICE

This NOTICE is to advise you that in the event you have a question or complaint about this insurance, please write to us at:

[Key Benefit Administrators
8330 Allison Pointe Trail
Indianapolis, IN 46250
Or, call us at: (317) 284-7164]

PART I - SCHEDULE OF BENEFITS

Insurance benefits are determined by this Schedule of Benefits and the terms of the Policy.

[Benefit	Benefit Amount
Inpatient Hospital Benefit	
Inpatient Hospital Benefit Year Maximum	
per Insured Person	[$500 – $10,000]
per family	3 times the Inpatient Hospital Benefit Year Maximum per Insured Person
Outpatient Hospital Benefit	
Outpatient Hospital Benefit Year Maximum	
per Insured Person	[40-70%] of the Inpatient Hospital Benefit Year Maximum
per family	3 times the Outpatient Hospital Benefit Year Maximum per Insured Person
Ambulance Benefit	
(Accident Only)	
Ambulance Benefit Year Maximum	
per Insured Person	[$0-$350]
per family	3 times the Ambulance Benefit Year Maximum per Insured Person
[Physician Office Visit Benefit	
per visit per Insured Person	[$5 - $50] per visit]]

PART II - DEFINITIONS

When used in the Certificate the following words and phrases have the meaning given.

Accident means an external event occurring by chance or unintentionally after the Insured Person's Effective Date of coverage. An Accident must be independent of any Sickness.

Actively at Work/Active Employment means the Insured Person is performing the material and substantial duties of the Insured Person's regular occupation on a full-time basis at the Insured Person's regular place of employment or at any business location to which the Insured Person is required to travel.

For the purposes of this definition, a vacation day, holiday or an authorized leave of absence not due to an Injury or Sickness is considered a regular work day.

Benefit Year means a period of one year which starts and ends at midnight on the dates shown in the employer's application.

Benefit Year Maximum means the amounts shown in the Schedule of Benefits.

Coinsurance/Copayment means the expenses covered and specified by the Insured Person's Health Benefit Plan as being the amount, other than deductibles, to be paid by the Insured Person.

Company means Companion Life Insurance Company, Columbia, South Carolina.

Complications of Pregnancy means any of the following: 1) a condition that, while affected by pregnancy, is still classified by accepted medical standards as a Sickness apart from the normal bodily changes that accompany pregnancy; 2) a non-elective cesarean section; 3) an extra uterine or ectopic pregnancy; or 4) a spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include: false labor, premature labor, high risk pregnancy or delivery, occasional spotting, Physician-prescribed rest, morning sickness, pre-eclampsia or placenta previa or similar conditions that occur in a difficult pregnancy.

Covered Charge means those expenses described in the Policy that are payable under both the Policy and the Insured Person's Health Benefit Plan. Expenses that are excluded under either the Policy or the Insured Person's Health Benefit Plan are not Covered Charges.

Dependent means any of the following whose coverage under the Policy has become effective and has not ended:

1. the Insured's lawful spouse;
2. the unmarried Dependent child or children of the Insured or of the Insured's spouse who are under 19 years of age (23 years of age if a full-time student); and
3. the unmarried handicapped Dependent child of the Insured or of the Insured's spouse who has attained age 19, provided such child was an Insured Person on the day immediately prior to attaining age 19, is mentally handicapped or physically incapable of earning his or her own living. Proof of incapacity must be furnished to the Company, but not more than once in any 12-month period.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree. Full-time, as used in this definition, means actively attending at least the minimum number of hours of class a week the school considers as full-time status.

A spouse or child covered under the Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both covered as Insureds, a child will be the Dependent of only one parent.

Effective Date means, for the Policy, the date shown in the Policy face page. Effective Date means, for an Insured Person, the date the Insured Person becomes covered under the Policy as shown in the Insured's Certificate. The Effective Date will begin at 12:01 a.m. Local Time at the Policyholder's business address.

Health Benefit Plan means any major medical or comprehensive medical plan through which an Insured Person has coverage. It may be a self-funded plan or provided through insurance. Health Benefit Plan does not include any limited medical program, Medicare, Medicaid, CHAMPUS, or TRICARE.

Hospital means an institution that meets all the following requirements:

1. it must be operated according to law;
2. it must give 24-hour medical care, diagnosis and treatment to the sick or injured on an inpatient basis;
3. it must provide diagnostic and surgical facilities supervised by Physicians;
4. Registered Nurses must be on 24-hour call or duty; and
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Hospital does not mean a convalescent, nursing, rest or extended care facility or a facility operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facility is operated as a separate institution by a Hospital.

Immediate Family means the Insured or the Insured Person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing with that Insured Person.

Injury means bodily injury sustained directly and independently of all other causes, which results in loss covered by the Policy. The Injury must occur and the loss must begin while the coverage for the Insured Person is in force under the Policy.

Inpatient means that the Insured Person is a registered bed patient in a Hospital for more than 23 continuous hours and is charged room and board by the facility. The Insured Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician.

Insured means an employee of the Policyholder whose coverage under the Policy has become effective and has not ended. The Insured must be Actively at Work with the Policyholder.

Insured Person means either an Insured or Dependent.

Late Entrant means a person who applies for coverage under the Policy more than 31 days after he or she initially becomes eligible.

Outpatient means the Insured Person is not an Inpatient when covered services are received.

Physician means a person licensed by the state in which he or she is a resident to practice the healing arts. He or she must be practicing within the scope of his or her license for the service or treatment given. He or she may not be the Insured Person or a member of the Insured Person's Immediate Family.

Policy means the contract issued to the Policyholder providing the benefits described.

Policyholder means the employer to whom the Policy is issued as shown in the Policy.

Regular and Customary Activities means: 1) for the Insured or a working Dependent, he or she is actively performing all the duties of his or her regular occupation; and 2) for a non-working Dependent, he or she is regularly performing the normal activities of a person of like age and good health.

Schedule of Benefits means the schedule in the Policy or Certificate which contains the benefits provided by the Policy.

Sickness means a bodily disorder, disease or illness that begins while the Insured Person's coverage is in force, including Complications of Pregnancy.

Total Disability/Totally Disabled means that because of Injury or Sickness, the Insured Person cannot perform the Insured Person's Regular and Customary Activities. The loss of a professional or occupational license for any reason does not, in itself, constitute Total Disability.

PART III - ELIGIBILITY AND EFFECTIVE DATE

New eligible persons will be added from time to time. In no event will coverage for any person become effective before the Policy Effective Date.

Insured Eligibility and Effective Date. Eligibility requirements are defined in the Policyholder's application. To be eligible, the Insured must be covered under a Health Benefit Plan. Coverage will be effective on the first day of the month, subject to approval of the Insured's individual enrollment form and payment of the first premium, provided the Insured is Actively at Work.

If the Insured is not engaged in the Insured's Regular and Customary Activities on the day coverage would otherwise begin, coverage will begin on the first day of the month following the day the Insured returns to Active Employment.

Dependent Eligibility and Effective Date. Insurance may be available to Dependents only if the Insured is eligible for such insurance under the Policy. An Insured's Dependents will be eligible for insurance under the Policy if the Dependent meets the eligibility requirements in the Policyholder's application and is covered under a Health Benefit Plan. Coverage will be effective on the first day of the month, subject to approval of the Dependent's individual enrollment form and payment of the first premium, provided the Dependent is engaging in the Dependent's Regular and Customary Activities.

If the Dependent is not engaged in the Dependent's Regular and Customary Activities on the day coverage would otherwise begin, coverage will begin on the first day of the month following the day the Dependent engages in the Dependent's Regular and Customary Activities. In no event will coverage for any Dependent become effective before the Insured's Effective Date.

Newborn and Adopted Children Eligibility and Effective Date. Coverage under the Policy for a newborn child, adopted child, child placed with the Insured for adoption, or child for whom the Insured is a party in a suit to adopt will be effective from the moment of birth, adoption, placement, or filing of such suit. Coverage for a newly born child will include coverage for Injury, Sickness, congenital defects, birth abnormalities and premature birth. In no event will coverage for such child become effective before the Insured's Effective Date.

We will pay benefits for a newborn child of the Insured until that child is 90 days old. Coverage may be continued beyond 90 days if the Insured notifies Us of the child's birth and pays the required premium, if any.

Adopted children will be covered on the same basis as a newborn child from the date of the filing of a petition for adoption if the Insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the date of birth. Coverage will cease on the date the child is removed from placement and the Insured's legal obligation terminates.

In no event will coverage for such child become effective before the Insured's Effective date.

PART IV - BENEFITS

The following benefits are payable if the Insured Person is covered by a Health Benefit Plan when the Covered Charges are incurred. Each benefit is subject to the terms, conditions, limitations, exclusions and Benefit Year Maximums as described herein.

Inpatient Hospital Benefit. The Company will pay the benefit shown in the Schedule of Benefits for Covered Charges incurred by an Insured Person if:

1. the Covered Charges are incurred while the Insured Person is an Inpatient; and
2. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Inpatient Hospital Benefit shown in the Schedule of Benefits.

Outpatient Hospital Benefit. The Company will pay the benefit shown in the Schedule of Benefits for Covered Charges incurred by an Insured Person if:

1. the Covered Charges are for:
   a. treatment in a Hospital emergency room for Injury due to an Accident when the Insured Person is not subsequently considered an Inpatient;
   b. surgery performed in a Hospital Outpatient facility or a free-standing Outpatient surgery center; or
   c. radiological diagnostic testing performed in a Hospital Outpatient facility or a Magnetic Resonance Imaging (MRI) facility; and
2. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Outpatient Hospital Benefit shown in the Schedule of Benefits.

Ambulance Benefit. The Company will pay the benefit shown in the Schedule of Benefits if an Insured Person requires ambulance transportation to a Hospital or emergency center for Injuries sustained in an Accident. Ambulance transportation must be within 72 hours of the Accident, and be provided by a licensed professional ambulance company.

Benefits are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Ambulance Benefit shown in the Schedule of Benefits.

[Physician Office Visit Benefit. The Company will pay the benefit shown in the Schedule of Benefits if the Insured Person incurs a Covered Charge as the result of:

1. treatment by a Physician due to Sickness;
2. treatment by a Physician for an Injury due to an Accident; or
3. routine well child examinations and immunizations for Dependent children.

Benefits are only payable if the Covered Charges are incurred while the Insured Person is not an Inpatient.]

PART V - LIMITATIONS AND EXCLUSIONS

Limitations

Waiting Period for Late Entrants. [Benefits for Late Entrants will be limited to the Physician Office Visit Benefit during the Waiting Period.] After the expiration of the Waiting Period, Late Entrants will be eligible for all benefits listed in the Schedule of Benefits for any Covered Charge that is incurred after such Waiting Period. For this provision, "Waiting Period" means the first 30 days following the Late Entrant's Effective Date.

Exclusions

The Policy does not provide any benefits for the following:

1. any expenses incurred during any period the Insured Person does not have coverage under a Health Benefit Plan;
2. suicide or any attempt thereat, while sane or insane (in Colorado or Missouri, while sane);
3. any intentionally self-inflicted Injury or Sickness, while sane or insane (in Colorado or Missouri, while sane);
4. rest care or rehabilitative care and treatment;
5. voluntary abortion except, with respect to the Insured or the Insured's Dependent spouse:
   a. where the Insured's or the Insured's Dependent spouse's life would be endangered if the fetus were carried to term; or
   b. where medical complications have arisen from abortion;
6. Pregnancy of a Dependent child, except Complications of Pregnancy;
7. any Injury or Sickness as a result of Participation in a Riot, civil commotion, civil disobedience or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law;
8. an Insured Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause of loss occurred. A violation of law includes both misdemeanor and felony violations;
9. participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, scuba diving, stunt driving, rock climbing, flying ultra-light aircraft, skydiving, hang gliding or any hazardous sports activity for exhibition purposes;
10. Injury or Sickness as a result of air travel, except;
    a. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
    b. as a passenger for transportation only and not as a pilot or crew member;
11. any Injury that occurs while an Insured Person has been determined to be intoxicated:
    a. by judicial or administrative judgment or order;
    b. by evidence of an alcohol concentration in the Insured Person's blood, breath or urine which equals or exceeds the limits set by applicable motor vehicle laws; or
    c. by other evidence demonstrating the Insured Person was under the influence of any alcohol, narcotic, barbiturate or hallucinatory drug, unless the same was administered on the advice of a Physician and was taken according to the prescribed dosage;

    and the use of such substance was a proximate cause of the Injury;
12. alcoholism or drug use, unless administered on the advice of a Physician and was taken according to the prescribed dosage;
13. procedures associated with sex changes;
14. any treatment, drugs or surgery considered experimental by the American Medical Association, the Health Care Finance Administration or the Federal Drug Administration;
15. any loss while the Insured Person is in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. Upon notice to the Company of entering the Armed Forces, the Company will return to the Insured Person pro rata any premium paid, less any benefits paid, for any period during which the Insured Person is in such service;
16. Injury or Sickness for which compensation is payable under any Workers' Compensation Law, any Occupational Disease Law or similar legislation;
17. mental illness or functional or organic nervous disorders, regardless of the cause;

18. dental or vision services, including, but not limited to, treatment, surgery, extractions or x-rays, unless:
    a. resulting from an Injury occurring while the Insured Person's coverage under the Policy is in force and if performed within 12 months of the date of such Accident; or
    b. due to congenital disease or anomaly of a Dependent newborn child;
19. routine examinations, [other than well child examinations if the Physician Office Visit Benefit is listed in the Schedule of Benefits,] such as health exams, periodic check-ups or routine physicals; or
20. any expense for which benefits are excluded under the Insured Person's Health Benefit Plan.

PART VI - TERMINATION OF INSURANCE

Termination of the Policy. The Policy may be terminated on the first of the following dates:

1. any premium due date on or after the first Policy Anniversary Date the Policyholder or the Company requests termination. Written notice must be provided to the other party at least 31 days prior to termination;
2. the next premium due date following the date the Policyholder's number of covered employees falls below the Company's guidelines; or
3. the date the Health Benefit Plan is modified, changed or terminated.

Termination of Insured's Coverage under the Policy. An Insured's coverage under the Policy automatically ends on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium has not been paid, except as provided in the Grace Period provision;
3. the date the Insured submits a fraudulent claim;
4. the date the Insured retires, is no longer an employee of the Policyholder, or is no longer Actively at Work; or
5. the date the Insured's Health Benefit Plan terminates.

Termination of Dependent's Coverage under the Policy. The insured Dependent's coverage under the Policy automatically ends on the first of the following dates:

1. the date the Insured's coverage terminates;
2. the date the required premium has not been paid, except as provided in the Grace Period provision;
3. the date the Dependent submits a fraudulent claim;
4. the date the Dependent ceases to be an eligible Dependent, as defined;
5. the date the Dependent's coverage under the Health Benefit Plan terminates; or
6. the date the Policy is modified to exclude Dependent coverage.

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination.

Continuation of Coverage. Coverage under the Policy will continue to the earlier of: 1) 31 days following termination of an Insured Person's coverage, or 2) the day the Insured Person otherwise becomes entitled to similar benefits under another policy.

This provision will not apply if coverage under the Insured Person's Health Benefit Plan terminates and the Health Benefit Plan does not have a similar continuation of coverage provision.

Extension of Benefits. This provision applies if an Insured Person is Hospital confined or Totally Disabled on the termination date of the Policy, unless termination is due to nonpayment of premiums. The Company will pay the same benefits for the duration of any Hospital confinement or Total Disability, or 90 days thereafter, whichever occurs first, if: 1) the Insured Person has incurred Covered Charges before the termination date; and 2) any Hospital confinement or Total Disability begins before the termination date. No further premium payment is required to qualify for this extension of benefits.

This provision will not apply if coverage under the Insured Person's Health Benefit Plan terminates and the Health Benefit Plan does not have a similar extension of benefits provision.

PART VII - PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date.

Premium Changes. The Company has the right to change the premium rates on any premium due date on or after the first Policy Anniversary Date. The Company will provide written notice at least 31 days before the date of change. The premium rates also may be changed at any time the terms of the Policy are changed. If a change in the Health Benefit Plan's deductible, Coinsurance or Copayment changes the Company's risk under the Policy, premium rates may be changed as of the date the Company's risk changed.

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums that are due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period.

Unpaid Premium. When a claim is paid for Covered Charges during the grace period, any premium due and unpaid for the Insured will be deducted from the claim payment.

PART VIII - CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's Home Office or to the Company's authorized administrator or agents with sufficient information to identify the Insured Person, will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not send the forms within that time, the Insured Person can send written proof of the occurrence, character and extent of loss for which the claim is made, within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's Home Office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required. Proof of loss includes a copy of the Health Benefit Plan's explanation of benefits.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All benefits will be payable to the Insured. Any benefits payable on or after the Insured's death will be paid to the Beneficiary.

Beneficiary means the person or entity named on the Company's records to receive the benefit after the Insured dies. The Insured may name any person as Beneficiary. If two or more Beneficiaries are named, each will receive an equal portion of the benefit, unless the Insured designates otherwise.

The Insured may change the Beneficiary at any time on forms the Company provides, unless an irrevocable Beneficiary is named or the insurance is assigned. The change date is the date the written request is signed by the Insured. If the Company pays the benefit before the Company receives a change request, the Company is released from further liability under the Policy to the extent of the Company's payment. If the Beneficiary dies at the same time as the Insured, or within 15 days after the Insured dies, the Company will pay the benefits as if the Insured survived the Beneficiary.

If there is no designated Beneficiary when the Insured dies, the Company will pay the benefits to the first of the following living persons:

1. the Insured's spouse;
2. the Insured's children, equally;
3. the Insured's parents, equally; or
4. the Insured's brothers and sisters, equally.

If none of the above persons is living on the date of the Insured's death, the Company will pay the benefits to the Insured's estate.

If any benefit is payable to an estate or to a minor or person not otherwise competent to give a valid release, the Company may pay such benefit, up to the amount allowed by the law of the state in which the minor or incompetent resides. Such payment will be made to the legal guardian of the minor or incompetent. Any payment made by the Company in good faith under this provision will fully discharge the Company to the extent of the payment.

Right of Recovery. If payment for claims exceeds the maximum amount payable under any benefit provisions or riders of the Policy, the Company has the right to recover the excess of such payments.

Physical Examination. At the Company's expense, the Company has the right to have the Insured Person examined as often as necessary while a claim is pending.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person lives, the limit is extended to meet the minimum time allowed by such law.

PART IX - GENERAL PROVISIONS

Certificates. Certificates will be provided to Insureds. The Certificate will describe the coverage provided, to whom benefits are paid and the provisions of the Policy that apply to Insured Persons. The Certificate is not a part of the Policy. Any conflict between the terms of the Certificate and the Policy will be decided in favor of the Policy. A copy of the Policy may be examined at the office of the Policyholder.

Choice of Physician. The Insured Person is free to be treated by any Physician the Insured Person chooses.

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Policyholder's application, which is attached to the Policy when issued, and the Insured's individual enrollment form, if any, are the entire contract between the parties. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured or the Insured's Beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured or the Insured's Beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying a premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not they become insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as they relate to this insurance. The Company can authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Misstatement of Age. If the age of an Insured Person has been misstated, the Company will make an equitable adjustment of premiums. The Company will refund to the Insured any excess premium paid over the amount due for the correct benefit amount. The Company will request payment for any overdue premium for the correct benefit amount. If the misstatement is discovered after a benefit is due and payable, the Company will reduce or increase the benefit amount payable by the amount of excess or overdue premium due to the misstatement. If an Insured Person is not eligible for coverage because of age, the Company will refund all premiums paid on and/or after the date the Insured Person was no longer eligible.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

COMPANION LIFE INSURANCE COMPANY
P.O. BOX 100102
COLUMBIA, SC 29202-3102

[ABC Employer]
Group Supplemental Medical Expense Insurance
[Employer] [Policyholder] Application

EMPLOYER INFORMATION (Please type/print in ink)

Legal Name of [Employer] [Policyholder] (include d/b/a)			
Business Address: (Street)	(City)	(State)	(Zip Code)
Mailing Address (if other than above): (Street)	(City)	(State)	(Zip Code)
Contact Person:		Telephone Number	( )
[Email Address:	]	[Fax Number:	( )]
• Corporation	• Partnership	• Sole Proprietorship	• Other (Specify)
[If any subsidiary, affiliated company or division is to be insured or any employees are working at a location other than the address above, please explain and provide address(es):_____]			
[SIC Code:	]	[Nature of Business	]
[FEIN Number	]	[Years in Business: (Under Legal Name)	]

1. Do you continuously maintain a Health Benefit Plan? • Yes • No How many plans are in force?_____

   [Current Insurer's Name and Telephone Number:_____]
   [(enclose copy of current carrier billing)]

   Note: *This plan is available only while the Employer continuosly maintains an underlying Health Benefit Plan. The Employer shall immediately notify the Company or its authorized agent of any future changes to the Employer's current Health Benefit Plan.*

2. [Do you offer any other supplemental medical expense insurance coverage to your employees that provides benefits for the deductibles and coinsurance/co-pays applied to your employee's Health Benefit Plan? • Yes • No

   If Yes, will this insurance replace it? • Yes • No]

   [**Note:** *Employees and their dependents who are covered under any other supplemental medical expense insurance plan that provides benefits for such out-of-pocket expenses are not eligible for coverage under this plan.*]

3. [Will this plan be made available to eligible employees through an employee welfare benefit plan (or welfare plan), as defined in Section 3 (3) of the Employee Retirement Income Security Act of 1974 ("ERISA")? • Yes • No]

4. [Will this plan be offered as part of a Section 125 Plan (Cafeteria Plan)? • Yes • No]

ELIGIBILITY INFORMATION

[Classes of employees eligible for coverage:_____ _____ _____]

[Minimum required work hours per week: _____] [Number of employees working the required minimum hours:____]

[Number of employees electing coverage: _____] [Number of employees waiving coverage: _____]

[To be eligible to enroll in this plan:]
[All enrollees must be covered under [a] [The Employer's] [or another] Health Benefit Plan.]

[Employees must have been employed for at least the number of days required of the applicable waiting period shown in the enrollment information section of this Application.]

[Employees must be at least age 18.] [Dependent Spouse must be at least 18.]

[Dependent Children must be under age [19-27], ([21-27] if full-time student).]

Note: *Dependent Child Age Limits may vary by state. Full-time student status verification demonstrating the student is enrolled in at least [the minimum number of hours of class a week the school considers full-time status] [12 credit hours] will be required. Full-time enrollment must be maintained or the dependent child becomes ineligible.]*

PLAN SELECTION AND EFFECTIVE DATE

[Attach a copy or plan summary of the Employer's Health Benefit Plan to be utilized as the underlying medical plan to the Policy.]

Benefit Year: _____
Month Day--Month Day

[Plan [A]: [**Note:** *Employer must pay 100 % of [Plan [A]] base premium.*]
[Underlying Medical Plan Deductible:
Inpatient Hospital Benefit Amount: [•] [$_____] [$500-$10,000]
Outpatient Benefit Amount [•] [$_____] [40-70% of Inpatient Hospital Benefit]
[Ambulance Benefit (Accident Only) [•] [$ _____] [$0-350]]
[Physician Office Visit Benefit $ _____ [•] [$0-$50] [*available in $5 increments*]]

[Plan [B]: [**Note:** *Employer must pay 100% of [Plan [A]] base premium.*]
[Underlying Medical Plan Deductible:
Inpatient Hospital Benefit Amount: [•] [$_____] [$500-$10,000]
Outpatient Benefit Amount [•] [$_____] [40-70% of Inpatient Hospital Benefit]
[Ambulance Benefit (Accident Only) [•] [$ _____] [$0-350]]
[Physician Offive Visit Benefit $ _____ [•] [$0-$50] [available in $5 increments]]

- Prescription and non-prescription Enteral Formulas (Subject to coverage under the Employers underlying Medical Plan)

Requested Effective Date: 12:01 A.M. on the [• 1st] [• 15th] [____] day of _____ [or the
(Month) (Year)

- first of the month following approval on _____].

[**Note:** *If the employee is not actively at work, or an enrolled spouse and/or dependent child is unable to perform the majority of their normal activities of a person of like age in good health, coverage that individual will be deferred until the first of the month following their return to full eligibility status.*]

ENROLLMENT INFORMATION

[Waiting period for [new] employees (check one) • None • 30 Days • 60 Days • 90Days • Other
Waive waiting period for current employees: • Yes • No]

[Initial Enrollment Period from: _____to _____]

[Open Enrollment Period from: _____to_____ each year.]

The Employer shall provide the Company's authorized agents or enrollers direct accress to its employees to obtain enrollment forms through group meetings and individual interviews in a suitable location on the Employer's property during normal business hours or through any other means mutally agreed upon by both the Company and the Employer. Participation must meet the Company's minimum participation requirements. The Company reserves the right to withdraw from the enrollment and cancel any applications already obtained should these conditions not be satisfied.

PREMIUM/BILLING AND REMITTANCE

Insurance shall be:
• Non-contributory (Employer assumes entire cost of plan) • Contributory
Employer Pays _____% of employee premium
_____% of dependent premium

[Payroll Deduction Information:
[First payroll deduction date: _____] [Number of payroll deductions per year: _____] [Number of pay periods per year: _____]

[For 9-month or 10-month payroll deducts, check the months when no deducations will be made:

• Jan • Feb • Mar • Apr • May • June • July • Aug • Sept • Oct • Nov • Dec]]

[Billing Information : **(Select desired method)**
[• Self Bill]

[• List Bill: All list billed clients will receive a summary page stating the balance due. List bill detail can be viewed at [applicable web address].] If you require a paper bill, please check here • .]

[Group will remit payments: [• Weekly] [• Bi-Weekly] [• Semi-Monthly] [• Monthly] [• ACH]
Preferred Billing Sequence:
[• Alphabetical] [• Social Security Number] [• Employee ID] [• Other (please specify)_____]

[Are billings required for multiple locations? • Yes • No (If YES, attach listing.)]

[(**NOTE**: *Agent must be licensed and appointed in each state where enrollments are taken.*)]

[Send Bills to: [• Employer] [• Other_____]

Name of Employer's Designate *(if elected other than Employer*):

Billing Address: (Street) (City) (State) (Zip Code)
_____

Billing Contact Name:_____Phone # _____

Billing Contact Email Address:_____Billing Contact Fax#_____]

[(Employer's designate must be pre-approved by the Company or an authorized administrator.]

The Employer shall honor all payroll deduction authorization forms signed by its participating employees, if any, and pay the premiums to the Company when due. The Company customarily bills the Employer each momth for such premiums and the Employer shall forward the premiums due to the Company within 15 days of the receipt of the monthly billing. The Employer shall maintain records of all premiums deducted from its employees' wages while the Policy remains in force and for two years thereafter. These records shall always remain open to inspection and audit by the Company during normal business hours and for two years after the Policy has been terminated.

In the event of any misappropriation by the Employer, its employees or agents of funds owed to the Company, the Employer shall reimburse the Company for the Company's entire loss including any attorney fees and expenses incurred in collection and any benefits the Company would not have had to pay but for such misappropriation.

Do not terminate existing coverage until you have received confirmation of coverage from the Company.

[MAILING INSTRUCTIONS (Check only one box for each item):

[Policy] and Administrative Kit: • [Employer/Policyholder] • Agency • [Employer's Designate]

Employee Certificate Packets: • [Employer/Policyholder] • Agency • [Employer's Designate]

Agreement Section

I understand, and our agent has explained, the limitation and exclusions of the Policy.

All Statements made herein are complete and true as of the date I signed this Application and I understand that the Company will rely on these statements and this information as the basis for approving this Application.

I understand that no insurance will become effective without the approval of the Company. Do not cancel other coverage (if any) until notified by the Company of acceptance of this Application. [The Employer will pay the Administrator a monthly service fee of [$25.00].]

I understand and acknowledge that the Employer/Policyholder may terminate the Policy by providing written notice to the Company at least [30-90] days prior to termination. The Company may terminate the Policy on [any date] [any premium due Date] [the first day of any month] on or after the first Policy Anniversary Date by providing written notice to the Employer/Policyholder at least [31] days prior to termination. The Employer/Policyholder is responsible for notifying the participating employee of the termination or non-renewal of the Policy.

I understand and acknowledge that the Company and the Employer/Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

I understand that any misrepresentation on this Application by the Employer or any of the Employer's agents or employees may result in the cancellation or recession of any Policy issued based on this Application.

[I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this Application for the Employer/Policyholder's state of domicile.] [Place fraud notice here.]

_____ _____

Printed or Typed Name of Employer Officer, Owner or Partner Title

_____ _____

Signature of Employer Officer, Owner of Partner Date

[PRODUCER'S INFORMATION

Writing Producer [(Must be an Agent, not an Agency)]

[Name_____ Agent Number_____ Group Split _____%]

Additional Producer [(Must be an Agent, not an Agency)]

[Name_____ Agent Number _____ Group Split _____%]

Additional Producer [(Must be an Agent, not an Agency)]

[Name_____ Agent Number _____ Group Split _____%]

Additional Producer [(Must be an Agent, not an Agency)]

[Name_____ Agent Number _____ Group Split _____%]

Additional Producer [(Must be an Agent, not an Agency)]

[Name_____ Agent Number _____ Group Split _____%]
[Total Group Split (Must Equal 100%) 100%]]

[PRODUCER'S STATEMENT

I understand that I represent the interests of the applicant for insurance, not the Insurance Company or the Administrator. I have advised the applicant not to cancel any existing coverage unless and until notified in writing. I understand that I have no right to bind this coverage or alter the terms of the Policy in any matter. All Policy limitations and exclusions have been explained to the applicant. My signature below confirms that I am properly licensed and appointed with Companion Life Insurance Company in the state (s) of application as of the signing of this Application.

_____ _____

[Writing] Producer's Signature Date

Agent # _____]

FRAUD WARNING NOTICE	
[For residents of all states {except the following:)]	[Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.]
[Arkansas]	[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]
[Colorado]	[It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within Department of Regulatory Agencies.]
[District of Columbia]	[Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.]
[Florida]	[Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information in guilty of a felony in the third degree.]
[Kentucky]	[Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]
[Louisiana]	[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]
[Maine] [Tennessee]	[It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]
[Nebraska]	[Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.]
[New Mexico]	[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Pennsylvania]	[Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

COMPANION LIFE INSURANCE COMPANY
P.O. BOX 100102
COLUMBIA, SC 29202-3102

[ABC Employer]
Group Supplemental Medical Expense Insurance
[Employee] Enrollment Form

~ New Enrollment ~ Add Dependents - Certificate # _____ ~ Increase Coverage - Certificate # _____

Group Name _____ Group Number _____ Location [or ~COBRA Participant] _____

Employee Information (Please type/print in ink)

Name: (Last) (First) (Middle Initial)	Social Security number	Home Telephone Number ( )
Home Address: (Street) (City) (State) (Zip Code)		
[Fax Number: ( )]	[Email Address:]	
Date of Birth: [Age:]	Gender: ~Male ~Female	
[Occupation (Title and Industry)]	[Work Telephone Number: ( )]	Date of Hire:
[Avg hours worked per week]	[Annual Salary:]	Employee ID:

[Dependent Information (Complete only for Dependents to be covered under this plan)

Dependents' Name: (First and Last)	Gender	Date of Birth	[Social Security Number]	[Date of Marriage[1]:
Spouse[2]	~M ~F	___/____/____		___/____/____]
Child	~M ~F	___/____/____		Full-Time Student: ~Yes ~No
Child	~M ~F	___/____/____		~Yes ~No
Child	~M ~F	___/____/____		~Yes ~No

(Attach a separate sheet for additional children)]

Current Coverage

Do all purposed insureds participate in the employer's [(or another)] Health Benefit Plan? ~Yes ~No

If **NO**, list the purposed insureds who will be excluded from coverage._____

1. Are any proposed insureds for coverage covered by an Title XIX program (e.g., Medicaid, Medicare, Champus or Tricare)?
~Yes ~No If **YES**, list the proposed insureds who will be excluded from coverage_____

Payroll Mode: [~Weekly] [~Bi-weekly] [~Semi-Monthly] [~ Monthly] ~Other _____]

Coverage Selection

[~Employee] [~Employee + Spouse[2]] [~Employee + Children] [~Employee + Family]
[~Employee + 1 Dependent] [~Employee + 2 or more dependents] [~Decline Coverage]

[~Plan A] [~Plan B] [~ Plan C]

[[{Employer Paid Benefit Amount}]	[Voluntary Benefit Amount[3]]	[Premium per Pay Period]
[$_____Inpatient]	[$_____Inpatient]	[Employer's $_____]
[$_____Outpatient]	[$_____ Outpatient]	[Employee's $_____]
[$_____Office Visit]	[$_____Office Visit]	[Total $_____]]

[[1]Marriage or Equivalent, as defined by governing State law]
[[2]Spouse or equivalent, as defined by governing State law.]
[[3]Voluntary benefit will only be issued when the required participation is met.]

[Beneficiary for Benefits Payable After an Insured Person's Death:

[Primary Beneficiary Relationship

_____ _____]

(Last) (First) (Middle Initial)

[Contingent Beneficiary Relationship

_____ _____]

(Last) (First) (Middle Initial)

You will be the beneficiary for all Dependents covered under the Policy.]

[~ Declination of Coverage:

[This section must be completed if you are declining coverage for yourself [and/or Dependents].] [I have been given the opportunity to enroll for group insurance provided through Companion Life Insurance Company. The reason I am not applying for coverage is: _____]

[I understand the Effective Date of Coverage for myself [and/or my Dependents] may not be available until the next Open Enrollment Period.]]

Enrollee's Statements and Agreements

I represent that all statements and answers made on or attached hereto are true and complete as of the date I signed this Enrollment Form. I understand that any false statements herein which materially affect the acceptance of the risk or hazard assumed may result in loss of coverage under the Policy/Certificate to which this Enrollment Form is attached.

I understand that I must be actively at work for the required number of hours specified in the group policy and/or my employer's application in order to maintain coverage. I currently participate in my employer's [(or another)] Health Benefit Plan. I understand that coverage will be delayed for any Dependent who is not engaged in his or her regular and customary activities on the day coverage would otherwise begin.

I understand there is a benefit waiting period for a late entrant.

[I authorize the required payroll deductions associated with my elected coverage and the coverage of my Dependents, if any. I reserve the right to revoke this deduction at any time with written notification to the Company and my Employer.]

[I hereby represent that I have reviewed the fraud notice {if applicable} included with this Enrollment Form for my state of residence.] [Place fraud statement here.]

Employee's Signature • _____ Date: _____

Spouse's Signature • _____ Date: _____
(if applicable)

Licensed Representative's Name _____ Agent Number _____

Licensed Representative's Signature_____

FRAUD WARNING NOTICE	
[For residents of all states [except the following:)]	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.]
[Arkansas]	[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]
[Colorado]	[It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within then Department of Regulatory Agencies.]
[District of Columbia]	[Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.]
[Florida]	[Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.]
[Kentucky]	[Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]
[Louisiana]	[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]
[Maine[[Tennessee]	[It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]
[Nebraska]	[Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.]
[New Mexico]	[Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]
[Pennsylvania]	[Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/07/2010
Comments:			
Attachment:			

AR - READABILITY CERTIFICATION.PDF

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	05/07/2010
Bypass Reason:	Not applicable to group filings		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	05/07/2010
Bypass Reason:	Submitted for approval under the Forms Tab		
Comments:			

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Companion Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GAPP-4100	40.5
GAPC-4100	40.5
GAPEMP-4100	47.7
GAPENR-4100	45.6

Signed: 

Name: Karl Kemmerlin

Title: Vice President and CFO

Date: May 4, 2010

SERFF Tracking Number:	*CMLX-126613507*	*State:*	*Arkansas*
Filing Company:	*Companion Life Insurance Company*	*State Tracking Number:*	*45580*
Company Tracking Number:	*HH AR0012201F01*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*HOEM01GR10*		
Project Name/Number:	*HOEM01GR10/HH AR0012201F01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/04/2010	Form	Group Supplemental Medical Expense Insurance Certificate	05/12/2010	GAPC-4100.PDF (Superceded)

COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200
Columbia, SC 29223

POLICY NUMBER:	**[MG-101]**
POLICYHOLDER:	**[ABC Employer]**
STATE OF ISSUE:	**[South Carolina]**
CERTIFICATE EFFECTIVE DATE:	**[Month, Day, Year]**

The Certificate is issued to Insureds of the Policyholder whose coverage is in effect according to the Company's records.

The Certificate describes the principal provisions of the Policy. Benefits are provided only while coverage is in force for an Insured Person according to the terms of the Policy.

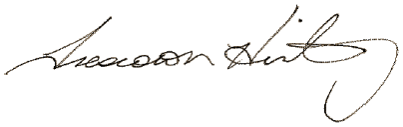
All periods of insurance begin and end at 12:01 a.m. Local Time at the Policyholder's business address.

This Certificate replaces all certificates that may have been previously issued to the Insured under the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Policy is issued by Companion Life Insurance Company at Columbia, South Carolina on the Policy Effective Date.

COMPANION LIFE INSURANCE COMPANY



President

GROUP SUPPLEMENTAL MEDICAL EXPENSE INSURANCE CERTIFICATE
THIS IS A LIMITED BENEFIT CERTIFICATE
Please read the Certificate carefully.

TABLE OF CONTENTS

NOTICE

This NOTICE is to advise you that in the event you have a question or complaint about this insurance, please write to us at:

[Key Benefit Administrators
8330 Allison Pointe Trail
Indianapolis, IN 46250
Or, call us at: (317) 284-7164]

PART I - SCHEDULE OF BENEFITS

Insurance benefits are determined by this Schedule of Benefits and the terms of the Policy.

[Benefit	Benefit Amount
Inpatient Hospital Benefit	
Inpatient Hospital Benefit Year Maximum	
per Insured Person	[$500 – $10,000]
per family	3 times the Inpatient Hospital Benefit Year Maximum per Insured Person
Outpatient Hospital Benefit	
Outpatient Hospital Benefit Year Maximum	
per Insured Person	[40-70%] of the Inpatient Hospital Benefit Year Maximum
per family	3 times the Outpatient Hospital Benefit Year Maximum per Insured Person
Ambulance Benefit	
(Accident Only)	
Ambulance Benefit Year Maximum	
per Insured Person	[$0-$350]
per family	3 times the Ambulance Benefit Year Maximum per Insured Person
[Physician Office Visit Benefit	
per visit per Insured Person	[$5 - $50] per visit]]

PART II - DEFINITIONS

When used in the Certificate the following words and phrases have the meaning given.

Accident means an external event occurring by chance or unintentionally after the Insured Person's Effective Date of coverage. An Accident must be independent of any Sickness.

Actively at Work/Active Employment means the Insured Person is performing the material and substantial duties of the Insured Person's regular occupation on a full-time basis at the Insured Person's regular place of employment or at any business location to which the Insured Person is required to travel.

For the purposes of this definition, a vacation day, holiday or an authorized leave of absence not due to an Injury or Sickness is considered a regular work day.

Benefit Year means a period of one year which starts and ends at midnight on the dates shown in the employer's application.

Benefit Year Maximum means the amounts shown in the Schedule of Benefits.

Coinsurance/Copayment means the expenses covered and specified by the Insured Person's Health Benefit Plan as being the amount, other than deductibles, to be paid by the Insured Person.

Company means Companion Life Insurance Company, Columbia, South Carolina.

Complications of Pregnancy means any of the following: 1) a condition that, while affected by pregnancy, is still classified by accepted medical standards as a Sickness apart from the normal bodily changes that accompany pregnancy; 2) a non-elective cesarean section; 3) an extra uterine or ectopic pregnancy; or 4) a spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include: false labor, premature labor, high risk pregnancy or delivery, occasional spotting, Physician-prescribed rest, morning sickness, pre-eclampsia or placenta previa or similar conditions that occur in a difficult pregnancy.

Covered Charge means those expenses described in the Policy that are payable under both the Policy and the Insured Person's Health Benefit Plan. Expenses that are excluded under either the Policy or the Insured Person's Health Benefit Plan are not Covered Charges.

Dependent means any of the following whose coverage under the Policy has become effective and has not ended:

1. the Insured's lawful spouse;
2. the unmarried Dependent child or children of the Insured or of the Insured's spouse who are under 19 years of age (23 years of age if a full-time student); and
3. the unmarried handicapped Dependent child of the Insured or of the Insured's spouse who has attained age 19, provided such child was an Insured Person on the day immediately prior to attaining age 19, is mentally handicapped or physically incapable of earning his or her own living. Proof of incapacity must be furnished to the Company, but not more than once in any 12-month period.

Dependent includes a step-child, foster child, legally adopted child, child for whom the Insured is a party to a suit for adoption, child who has been placed in the Insured's home for adoption and child under the Insured's legal guardianship, if such child depends primarily on the Insured for support. Dependent will also include a child for whom the Insured is legally required to support due to court order or divorce decree. Full-time, as used in this definition, means actively attending at least the minimum number of hours of class a week the school considers as full-time status.

A spouse or child covered under the Policy as an Insured will not be eligible as a Dependent. If a husband and wife are both covered as Insureds, a child will be the Dependent of only one parent.

Effective Date means, for the Policy, the date shown in the Policy face page. Effective Date means, for an Insured Person, the date the Insured Person becomes covered under the Policy as shown in the Insured's Certificate. The Effective Date will begin at 12:01 a.m. Local Time at the Policyholder's business address.

Health Benefit Plan means any major medical or comprehensive medical plan through which an Insured Person has coverage. It may be a self-funded plan or provided through insurance. Health Benefit Plan does not include any limited medical program, Medicare, Medicaid, CHAMPUS, or TRICARE.

Hospital means an institution that meets all the following requirements:

1. it must be operated according to law;
2. it must give 24-hour medical care, diagnosis and treatment to the sick or injured on an inpatient basis;
3. it must provide diagnostic and surgical facilities supervised by Physicians;
4. Registered Nurses must be on 24-hour call or duty; and
5. the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Hospital does not mean a convalescent, nursing, rest or extended care facility or a facility operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facility is operated as a separate institution by a Hospital.

Immediate Family means the Insured or the Insured Person's spouse, parent, child, grandparent, brother, sister, in-law or any person residing with that Insured Person.

Injury means bodily injury sustained directly and independently of all other causes, which results in loss covered by the Policy. The Injury must occur and the loss must begin while the coverage for the Insured Person is in force under the Policy.

Inpatient means that the Insured Person is a registered bed patient in a Hospital for more than 23 continuous hours and is charged room and board by the facility. The Insured Person must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician.

Insured means an employee of the Policyholder whose coverage under the Policy has become effective and has not ended. The Insured must be Actively at Work with the Policyholder.

Insured Person means either an Insured or Dependent.

Late Entrant means a person who applies for coverage under the Policy more than 31 days after he or she initially becomes eligible.

Outpatient means the Insured Person is not an Inpatient when covered services are received.

Physician means a person licensed by the state in which he or she is a resident to practice the healing arts. He or she must be practicing within the scope of his or her license for the service or treatment given. He or she may not be the Insured Person or a member of the Insured Person's Immediate Family.

Policy means the contract issued to the Policyholder providing the benefits described.

Policyholder means the employer to whom the Policy is issued as shown in the Policy.

Regular and Customary Activities means: 1) for the Insured or a working Dependent, he or she is actively performing all the duties of his or her regular occupation; and 2) for a non-working Dependent, he or she is regularly performing the normal activities of a person of like age and good health.

Schedule of Benefits means the schedule in the Policy or Certificate which contains the benefits provided by the Policy.

Sickness means a bodily disorder, disease or illness that begins while the Insured Person's coverage is in force, including Complications of Pregnancy.

Total Disability/Totally Disabled means that because of Injury or Sickness, the Insured Person cannot perform the Insured Person's Regular and Customary Activities. The loss of a professional or occupational license for any reason does not, in itself, constitute Total Disability.

PART III - ELIGIBILITY AND EFFECTIVE DATE

New eligible persons will be added from time to time. In no event will coverage for any person become effective before the Policy Effective Date.

Insured Eligibility and Effective Date. Eligibility requirements are defined in the Policyholder's application. To be eligible, the Insured must be covered under a Health Benefit Plan. Coverage will be effective on the first day of the month, subject to approval of the Insured's individual enrollment form and payment of the first premium, provided the Insured is Actively at Work.

If the Insured is not engaged in the Insured's Regular and Customary Activities on the day coverage would otherwise begin, coverage will begin on the first day of the month following the day the Insured returns to Active Employment.

Dependent Eligibility and Effective Date. Insurance may be available to Dependents only if the Insured is eligible for such insurance under the Policy. An Insured's Dependents will be eligible for insurance under the Policy if the Dependent meets the eligibility requirements in the Policyholder's application and is covered under a Health Benefit Plan. Coverage will be effective on the first day of the month, subject to approval of the Dependent's individual enrollment form and payment of the first premium, provided the Dependent is engaging in the Dependent's Regular and Customary Activities.

If the Dependent is not engaged in the Dependent's Regular and Customary Activities on the day coverage would otherwise begin, coverage will begin on the first day of the month following the day the Dependent engages in the Dependent's Regular and Customary Activities. In no event will coverage for any Dependent become effective before the Insured's Effective Date.

Newborn and Adopted Children Eligibility and Effective Date. Coverage under the Policy for a newborn child, adopted child, child placed with the Insured for adoption, or child for whom the Insured is a party in a suit to adopt will be effective from the moment of birth, adoption, placement, or filing of such suit. Coverage for a newly born child will include coverage for Injury, Sickness, congenital defects, birth abnormalities and premature birth. In no event will coverage for such child become effective before the Insured's Effective Date.

We will pay benefits for a newborn child of the Insured until that child is 90 days old. Coverage may be continued beyond 90 days if the Insured notifies Us of the child's birth and pays the required premium, if any.

Adopted children will be covered on the same basis as a newborn child from the date of the filing of a petition for adoption if the Insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the date of birth. Coverage will cease on the date the child is removed from placement and the Insured's legal obligation terminates.

In no event will coverage for such child become effective before the Insured's Effective date.

PART IV - BENEFITS

The following benefits are payable if the Insured Person is covered by a Health Benefit Plan when the Covered Charges are incurred. Each benefit is subject to the terms, conditions, limitations, exclusions and Benefit Year Maximums as described herein.

Inpatient Hospital Benefit. The Company will pay the benefit shown in the Schedule of Benefits for Covered Charges incurred by an Insured Person if:

1. the Covered Charges are incurred while the Insured Person is an Inpatient; and
2. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Inpatient Hospital Benefit shown in the Schedule of Benefits.

Outpatient Hospital Benefit. The Company will pay the benefit shown in the Schedule of Benefits for Covered Charges incurred by an Insured Person if:

1. the Covered Charges are for:
   a. treatment in a Hospital emergency room for Injury due to an Accident when the Insured Person is not subsequently considered an Inpatient;
   b. surgery performed in a Hospital Outpatient facility or a free-standing Outpatient surgery center; or
   c. radiological diagnostic testing performed in a Hospital Outpatient facility or a Magnetic Resonance Imaging (MRI) facility; and
2. with respect to Late Entrants, the Covered Charges are incurred more than 30 days after the Late Entrant's Effective Date.

Benefits payable are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Outpatient Hospital Benefit shown in the Schedule of Benefits.

Ambulance Benefit. The Company will pay the benefit shown in the Schedule of Benefits if an Insured Person requires ambulance transportation to a Hospital or emergency center for Injuries sustained in an Accident. Ambulance transportation must be within 72 hours of the Accident, and be provided by a licensed professional ambulance company.

Benefits are limited to:

1. any deductible amount applied to the expenses covered by the Insured Person's Health Benefit Plan; and
2. any Coinsurance and/or Copayment amount applied to the expenses covered by the Insured Person's Health Benefit Plan.

The total benefits payable for each Insured Person during a Benefit Year will not exceed the Benefit Year Maximum under the Ambulance Benefit shown in the Schedule of Benefits.

[Physician Office Visit Benefit. The Company will pay the benefit shown in the Schedule of Benefits if the Insured Person incurs a Covered Charge as the result of:

1. treatment by a Physician due to Sickness;
2. treatment by a Physician for an Injury due to an Accident; or
3. routine well child examinations and immunizations for Dependent children.

Benefits are only payable if the Covered Charges are incurred while the Insured Person is not an Inpatient.]

PART V - LIMITATIONS AND EXCLUSIONS

Limitations

Waiting Period for Late Entrants. [Benefits for Late Entrants will be limited to the Physician Office Visit Benefit during the Waiting Period.] After the expiration of the Waiting Period, Late Entrants will be eligible for all benefits listed in the Schedule of Benefits for any Covered Charge that is incurred after such Waiting Period. For this provision, "Waiting Period" means the first 30 days following the Late Entrant's Effective Date.

Exclusions

The Policy does not provide any benefits for the following:

1. any expenses incurred during any period the Insured Person does not have coverage under a Health Benefit Plan;
2. suicide or any attempt thereat, while sane or insane (in Colorado or Missouri, while sane);
3. any intentionally self-inflicted Injury or Sickness, while sane or insane (in Colorado or Missouri, while sane);
4. rest care or rehabilitative care and treatment;
5. voluntary abortion except, with respect to the Insured or the Insured's Dependent spouse:
   a. where the Insured's or the Insured's Dependent spouse's life would be endangered if the fetus were carried to term; or
   b. where medical complications have arisen from abortion;
6. Pregnancy of a Dependent child, except Complications of Pregnancy;
7. any Injury or Sickness as a result of Participation in a Riot, civil commotion, civil disobedience or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority. For purposes of this exclusion, "Participation" means to take an active part in common with others; "Riot" means any use or threat to use force or violence or disturbance by three or more persons without authority of law;
8. an Insured Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause of loss occurred. A violation of law includes both misdemeanor and felony violations;
9. participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping, scuba diving, stunt driving, rock climbing, flying ultra-light aircraft, skydiving, hang gliding or any hazardous sports activity for exhibition purposes;
10. Injury or Sickness as a result of air travel, except;
    a. as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
    b. as a passenger for transportation only and not as a pilot or crew member;
11. any Injury that occurs while an Insured Person has been determined to be intoxicated:
    a. by judicial or administrative judgment or order;
    b. by evidence of an alcohol concentration in the Insured Person's blood, breath or urine which equals or exceeds the limits set by applicable motor vehicle laws; or
    c. by other evidence demonstrating the Insured Person was under the influence of any alcohol, narcotic, barbiturate or hallucinatory drug, unless the same was administered on the advice of a Physician and was taken according to the prescribed dosage;

    and the use of such substance was a proximate cause of the Injury;
12. alcoholism or drug use, unless administered on the advice of a Physician and was taken according to the prescribed dosage;
13. procedures associated with sex changes;
14. any treatment, drugs or surgery considered experimental by the American Medical Association, the Health Care Finance Administration or the Federal Drug Administration;
15. any loss while the Insured Person is in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. Upon notice to the Company of entering the Armed Forces, the Company will return to the Insured Person pro rata any premium paid, less any benefits paid, for any period during which the Insured Person is in such service;
16. Injury or Sickness for which compensation is payable under any Workers' Compensation Law, any Occupational Disease Law or similar legislation;
17. mental illness or functional or organic nervous disorders, regardless of the cause;

18. dental or vision services, including, but not limited to, treatment, surgery, extractions or x-rays, unless:
    a. resulting from an Injury occurring while the Insured Person's coverage under the Policy is in force and if performed within 12 months of the date of such Accident; or
    b. due to congenital disease or anomaly of a Dependent newborn child;
19. routine examinations, [other than well child examinations if the Physician Office Visit Benefit is listed in the Schedule of Benefits,] such as health exams, periodic check-ups or routine physicals; or
20. any expense for which benefits are excluded under the Insured Person's Health Benefit Plan.

PART VI - TERMINATION OF INSURANCE

Termination of the Policy. The Policy may be terminated on the first of the following dates:

1. any premium due date on or after the first Policy Anniversary Date the Policyholder or the Company requests termination. Written notice must be provided to the other party at least 31 days prior to termination;
2. the next premium due date following the date the Policyholder's number of covered employees falls below the Company's guidelines; or
3. the date the Health Benefit Plan is modified, changed or terminated.

Termination of Insured's Coverage under the Policy. An Insured's coverage under the Policy automatically ends on the first of the following dates:

1. the date the Policy terminates;
2. the date the required premium has not been paid, except as provided in the Grace Period provision;
3. the date the Insured submits a fraudulent claim;
4. the date the Insured retires, is no longer an employee of the Policyholder, or is no longer Actively at Work; or
5. the date the Insured's Health Benefit Plan terminates.

Termination of Dependent's Coverage under the Policy. The insured Dependent's coverage under the Policy automatically ends on the first of the following dates:

1. the date the Insured's coverage terminates;
2. the date the required premium has not been paid, except as provided in the Grace Period provision;
3. the date the Dependent submits a fraudulent claim;
4. the date the Dependent ceases to be an eligible Dependent, as defined;
5. the date the Dependent's coverage under the Health Benefit Plan terminates; or
6. the date the Policy is modified to exclude Dependent coverage.

Termination of the insurance of any Insured Person will be without prejudice to any claim originating before the date of termination.

Continuation of Coverage. Coverage under the Policy will continue to the earlier of: 1) 31 days following termination of an Insured Person's coverage, or 2) the day the Insured Person otherwise becomes entitled to similar benefits under another policy.

This provision will not apply if coverage under the Insured Person's Health Benefit Plan terminates and the Health Benefit Plan does not have a similar continuation of coverage provision.

Extension of Benefits. This provision applies if an Insured Person is Hospital confined or Totally Disabled on the termination date of the Policy, unless termination is due to nonpayment of premiums. The Company will pay the same benefits for the duration of any Hospital confinement or Total Disability, or 90 days thereafter, whichever occurs first, if: 1) the Insured Person has incurred Covered Charges before the termination date; and 2) any Hospital confinement or Total Disability begins before the termination date. No further premium payment is required to qualify for this extension of benefits.

This provision will not apply if coverage under the Insured Person's Health Benefit Plan terminates and the Health Benefit Plan does not have a similar extension of benefits provision.

PART VII - PREMIUMS

The Company provides insurance coverage in return for premium payment. Premiums are payable to the Company. The Insured Person's first premium is due on the Insured Person's Effective Date. Premiums must be paid to the Company on or before the due date.

Premium Changes. The Company has the right to change the premium rates on any premium due date on or after the first Policy Anniversary Date. The Company will provide written notice at least 31 days before the date of change. The premium rates also may be changed at any time the terms of the Policy are changed. If a change in the Health Benefit Plan's deductible, Coinsurance or Copayment changes the Company's risk under the Policy, premium rates may be changed as of the date the Company's risk changed.

Grace Period. The Policy has a 31-day grace period for the payment of each premium due after the first premium. Coverage will continue in force during the grace period. It will terminate at the end of the grace period if all premiums that are due are not paid. The Company will require payment of all premiums for the period this coverage continues in force, including the premiums for the grace period.

Unpaid Premium. When a claim is paid for Covered Charges during the grace period, any premium due and unpaid for the Insured will be deducted from the claim payment.

PART VIII - CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. Notice given by or for the Insured Person to the Company at the Company's Home Office or to the Company's authorized administrator or agents with sufficient information to identify the Insured Person, will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not send the forms within that time, the Insured Person can send written proof of the occurrence, character and extent of loss for which the claim is made, within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's Home Office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required. Proof of loss includes a copy of the Health Benefit Plan's explanation of benefits.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims. All benefits will be payable to the Insured. Any benefits payable on or after the Insured's death will be paid to the Beneficiary.

Beneficiary means the person or entity named on the Company's records to receive the benefit after the Insured dies. The Insured may name any person as Beneficiary. If two or more Beneficiaries are named, each will receive an equal portion of the benefit, unless the Insured designates otherwise.

The Insured may change the Beneficiary at any time on forms the Company provides, unless an irrevocable Beneficiary is named or the insurance is assigned. The change date is the date the written request is signed by the Insured. If the Company pays the benefit before the Company receives a change request, the Company is released from further liability under the Policy to the extent of the Company's payment. If the Beneficiary dies at the same time as the Insured, or within 15 days after the Insured dies, the Company will pay the benefits as if the Insured survived the Beneficiary.

If there is no designated Beneficiary when the Insured dies, the Company will pay the benefits to the first of the following living persons:

1. the Insured's spouse;
2. the Insured's children, equally;
3. the Insured's parents, equally; or
4. the Insured's brothers and sisters, equally.

If none of the above persons is living on the date of the Insured's death, the Company will pay the benefits to the Insured's estate.

If any benefit is payable to an estate or to a minor or person not otherwise competent to give a valid release, the Company may pay such benefit, up to the amount allowed by the law of the state in which the minor or incompetent resides. Such payment will be made to the legal guardian of the minor or incompetent. Any payment made by the Company in good faith under this provision will fully discharge the Company to the extent of the payment.

Right of Recovery. If payment for claims exceeds the maximum amount payable under any benefit provisions or riders of the Policy, the Company has the right to recover the excess of such payments.

Physical Examination. At the Company's expense, the Company has the right to have the Insured Person examined as often as necessary while a claim is pending.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person lives, the limit is extended to meet the minimum time allowed by such law.

PART IX - GENERAL PROVISIONS

Certificates. Certificates will be provided to Insureds. The Certificate will describe the coverage provided, to whom benefits are paid and the provisions of the Policy that apply to Insured Persons. The Certificate is not a part of the Policy. Any conflict between the terms of the Certificate and the Policy will be decided in favor of the Policy. A copy of the Policy may be examined at the office of the Policyholder.

Choice of Physician. The Insured Person is free to be treated by any Physician the Insured Person chooses.

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform with the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Policyholder's application, which is attached to the Policy when issued, and the Insured's individual enrollment form, if any, are the entire contract between the parties. All statements made by the Policyholder or an Insured will, in the absence of fraud, be deemed representations and not warranties and no such statement shall be used in defense to a claim hereunder unless it is contained in a written instrument signed by the Policyholder, the Insured or the Insured's Beneficiary or personal representative, a copy of which has been furnished to the Policyholder, the Insured or the Insured's Beneficiary or personal representative.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying a premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Incontestability. After the Policy has been in force for two years, it can only be contested for nonpayment of premiums. No statement made by an Insured Person can be used in a contest after the Insured Person's insurance has been in force for two years during the Insured Person's lifetime. No statement an Insured Person makes can be used in a contest unless it is in writing and signed by the Insured Person.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not they become insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as they relate to this insurance. The Company can authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Misstatement of Age. If the age of an Insured Person has been misstated, the Company will make an equitable adjustment of premiums. The Company will refund to the Insured any excess premium paid over the amount due for the correct benefit amount. The Company will request payment for any overdue premium for the correct benefit amount. If the misstatement is discovered after a benefit is due and payable, the Company will reduce or increase the benefit amount payable by the amount of excess or overdue premium due to the misstatement. If an Insured Person is not eligible for coverage because of age, the Company will refund all premiums paid on and/or after the date the Insured Person was no longer eligible.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.